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#### **STRATEGY AND PLAN OF ACTION ON STRENGTHENING THE HEALTH SYSTEM TO ADDRESS VIOLENCE AGAINST WOMEN**

##### **Introduction**

1. Violence against women, an extreme form of gender inequality, is a public health and human rights problem that affects large numbers of women worldwide (1). In the Region of the Americas (“the Region”), one in three women has experienced intimate partner violence or sexual violence by a non-partner during her lifetime (1). Women belonging to some ethnically marginalized and indigenous groups are often at higher risk (2, 3).
  2. The United Nations (UN) Declaration on the Elimination of Violence against Women (A/RES/48/104) defines violence against women as “any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life” (4).
  3. Violence against women takes many forms, but sexual, physical and emotional violence by a male partner are the most prevalent forms (5). Violence against women has long lasting and profound consequences for women’s physical and mental health; children’s health and psychosocial development; the well-being of families and communities; and national budgets and economic development (1).
  4. Preventing and responding effectively to violence against women requires coordinated, multisectoral action. The Pan American Health Organization’s Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women for 2015-2025 (“Strategy and Plan of Action”) offers a concrete roadmap to address the Region’s priorities for preventing and responding to violence against women. The Strategy and Plan of Action is designed to step up efforts by Member States, the Pan American Sanitary Bureau (“the Bureau”), and international organizations. This
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document takes a public health approach and focuses on what health systems can do as a complement to important actions undertaken by other sectors.

5. The Bureau recognizes that violence can occur at all stages of life —childhood, adolescence, adulthood, and old age. All violence against male and female children and adults can lead to negative health outcomes that should be addressed by health systems. There are compelling reasons for a specific focus on violence against women, however, including its invisibility within national and international statistics, its social acceptability, the economic and social barriers to help-seeking (including shame and stigma), weak legal sanctions, and health systems' limited capacity to identify and care for survivors (6).

6. Violence against women has recently received significant international attention, creating momentum to catalyze change. Of particular note are the following:

- a) the World Health Assembly (WHA) resolution *Strengthening the role of the health system in addressing violence, in particular against women and girls, and against children*, adopted by consensus in May 2014 (7);
- b) review of the International Conference on Population and Development Beyond 2014 by the United Nations Population Fund (UNFPA) in which countries identified violence against women as an area of priority for action (8);
- c) efforts to report on violence against women in the 20-year anniversary of the Beijing Declaration and Platform for Action (Beijing+20) (9);
- d) the inclusion of a specific target on eliminating all forms of violence against women and girls within the 2030 Agenda for Sustainable Development (10).

## **Background**

7. As a result of *a*) efforts of women's organizations, *b*) increased commitment by governments, *c*) innovative public policies, and *d*) growing evidence on magnitude and consequences, the international community has increasingly recognized violence against women as a violation or abuse of human rights with important public health ramifications (11).

8. The Convention on the Elimination of All Forms of Discrimination against Women (1981) aimed to eliminate all forms of discrimination against women and the related General Recommendations. The 1993 Declaration on the Elimination of Violence against Women recognized "the urgent need for the universal application to women of the rights and principles with regard to equality, security, liberty, integrity and dignity of all human beings" (4). The 1994 Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women, known as the Convention of Belém do Pará, described violence against women as a violation of human rights and fundamental freedoms (3).

9. Many recent efforts across the UN system have sought to address violence against women, including the International Conference on Population and Development, the Beijing Declaration and Platform for Action, General Assembly and Human Rights Council resolutions, and meetings of the Commission on the Status of Women (12-15). In 2006, the Secretary-General's study "Ending violence against women: From words to action," called on the UN to take stronger action to address violence against women (11). In addition, the 2030 Agenda for Sustainable Development adopted a target on the elimination of all forms of violence against all women and girls under its stand-alone gender equality goal (10).

10. Various PAHO and World Health Organization (WHO) resolutions recognize violence as a worldwide public health problem and identify women as a group at increased risk of experiencing specific types of violence (16-19). The 2014 WHA resolution (*Strengthening the role of the health system in addressing violence, in particular against women and girls, and against children*) (WHA67.15) tasks WHO with the development of a Global Plan of Action to strengthen the role of the health system (7). As part of a synchronized effort, PAHO's Directing Council simultaneously tasked the Bureau with the development of this Strategy and Plan of Action on violence against women.

## **Situational Analysis**

### ***Forms and Prevalence of Violence against Women***

11. Many forms of violence disproportionately affect women (1). At the global level, the most common forms of violence against women include but are not limited to:

- a) intimate partner violence (physical, sexual, or psychological);
- b) sexual violence (including rape) by non-partners;
- c) child, early, and forced marriage;
- d) human trafficking, including forced prostitution and economic exploitation;
- e) female genital mutilation/cutting and other harmful traditional practices;
- f) femicide<sup>1</sup> and the killing of girls or women in the name of "honor";
- g) sexual harassment in schools and workplaces (20).

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<sup>1</sup> Two terms are commonly used to refer to female homicide: femicide and feminicide; however, there is no consensus on the distinction between the two and on which is the most adequate. The term "feminicide" was coined to refer specifically to the killing of women because they are women; some definitions also refer to the participation of the State by act or omission. In this document, the broader term "femicide" is used to emphasize the scarcity of information in the Region to determine the context of female homicides and the intention behind them, but the existence of both terms is recognized.

12. Levels of violence against women may be particularly high in situations of armed conflict, displacement, natural disasters and other humanitarian crises; and in institutional settings, such as prisons and facilities for individuals with mental illnesses. The perpetration of violence against women can also occur within the health system itself: the abuse of women within the context of patient–provider interactions, particularly during the provision of sexual and reproductive health services, including childbirth, is receiving increased attention in the Region and is being addressed by PAHO and WHO (21).

13. Workplace violence against women, including physical, sexual and psychological assault within health services raises many of the concerns presented in this document and is being addressed by efforts to improve workers health and well-being and increase women’s participation in the workforce (22).

14. In some settings, women from minority ethnic groups may be at higher risk of violence than other women. An analysis of data from Bolivia found a twofold higher risk of partner violence against women who spoke a language other than Spanish at home (23). In Ecuador, women who self-identified as indigenous reported higher levels of partner violence than women who identified as mestizo or white (2). A study in Mexico among indigenous women seeking health services found that 25.55% of those interviewed reported experiencing some form of violence by a current partner, with wide variations across geographic regions.<sup>2</sup> In Canada, aboriginal women are nearly three times as likely to experience violence as non-aboriginal women (24). In many settings, however, there is a paucity of data on the prevalence of violence against women disaggregated by ethnicity/race, and more culturally relevant and methodologically rigorous research is needed.

15. Some evidence, including research from Canada, suggests that women who identify as lesbian or bisexual may be at higher risk of violence than women who identify as heterosexual (25), however there are limited data from the Region disaggregated by sex, gender identity, and sexual orientation. This is an area that requires more research.

16. Certain studies suggest that women with disabilities also face a higher risk of violence than other women. For example, a systematic review and meta-analysis found that individuals (both male and female) with disabilities are more likely to experience physical and sexual violence than their non-disabled counterparts (26).

17. Violence by an intimate partner is the most common form of violence experienced by women. WHO estimates that 30% of women in the Americas have experienced physical and/or sexual violence by a partner while 11% have experienced sexual violence by a non-partner (1).

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<sup>2</sup> The document can be found at: [http://www.insp.mx/images/stories/Produccion/pdf/100722\\_cp7.pdf](http://www.insp.mx/images/stories/Produccion/pdf/100722_cp7.pdf) (in Spanish).

18. Femicide is another important form of violence against women in the Region (27, 28). Femicide is generally understood to involve the intentional murder of women because they are women, but broader definitions include any killing of a woman or girl. Intimate partner femicide is the murder of a woman by her current or former partner, usually following a history of other forms of partner violence (29). Global data on femicide are limited due to a lack of systems to document motives for murder or the relationship between victims and perpetrators. However, WHO estimates that up to 38% of women murdered in the Region are killed by a partner or ex-partner (1).

19. The estimated prevalence of lifetime sexual violence against women by any perpetrator (including partners and non-partners) varies widely by study and site, but is substantial throughout the Region. An analysis of national survey data from eleven countries in the Region found that estimates of lifetime sexual violence against ever-married women (including forced sexual intercourse, forced sex acts, and unwanted sex due to fear) ranged from about 1 in 10 women (10.3%) in Paraguay (2008) to more than 1 in 4 women (27.2%) in Haiti (2005-2006) (2).

20. Data suggest that a significant number of women in the Region experience forced or unwanted sexual debut. When asked whether their first sexual intercourse was wanted or forced, between 1.8% of women in Nicaragua (2006-2007) and 21.2% of women in Haiti (2005-2006) reported forced sexual debut (2). Similarly, a study of six countries of the Organization of Eastern Caribbean States (2005-2006) found that forced sexual intercourse among females 15–24 years old ranged from 6% in Antigua and Barbuda to 12% in Saint Lucia (30). In Jamaica (2008–2009), only 4.7% of young women said their first sexual intercourse was “forced,” but nearly half (44.9%) said their first sexual intercourse was unwanted (2). Forced and unwanted sexual intercourse may contribute to adolescent pregnancy and HIV transmission, highlighting the need to address sexual violence as part of efforts to reduce unplanned pregnancy and HIV transmission in the Region.

### ***Risk and Protective Factors***

21. Research into risk and protective factors associated with violence against women has important limitations and gaps. First, most studies come from high-income countries and focus primarily on risk, rather than protective factors. Second, most use cross-sectional rather than longitudinal designs and thus provide limited evidence of causality. Finally, most studies examine individual rather than community or societal risk factors, which are key to prevention.

22. In spite of the shortcomings of existing research, it is clear that there is no single explanation for why certain individuals perpetrate violence against women or why such violence is more prevalent in certain communities. The existing evidence suggests that violence against women is rooted in gender inequalities and power imbalances between men and women but is also influenced by a complex interplay of factors at the individual, relationship, community, and societal levels, as articulated by the socio-ecological

framework. The figure in Annex A illustrates the risk factors associated with the perpetration of intimate partner violence and sexual violence, according to a socio-ecological model.

23. Individual factors associated with a higher risk of male perpetration and female experiences of violence against women include low educational attainment, childhood exposure to violence (either as a victim of child abuse or as a witness to intra-parental violence), alcohol and illicit drug use, and mental health conditions. Community and societal level factors associated with higher levels of intimate partner violence and non-partner sexual violence include weak community sanctions against violence, poverty, gender inequality and social norms that support the acceptability of violence (31).

24. Although violence against women has been found in virtually all settings where it has been researched, prevalence rates vary considerably between and within countries, suggesting that high levels of violence against women are not inevitable. There are ongoing efforts worldwide to identify effective prevention strategies. Attention has focused on promising results from strengthening legal sanctions against violence, challenging gender norms, investing in women's economic empowerment, reducing harmful use of alcohol, and addressing child abuse against both boys and girls. Greater investment is needed to understand the individual-, relationship-, community-, and societal-level factors that are amenable to change so that comprehensive, effective prevention strategies can be implemented at a broad scale.

### ***Health Consequences***

25. Violence against women has many under-recognized health consequences, including death due to femicide, suicide, HIV/AIDS and maternal mortality, as well as non-fatal effects ranging from injuries, sexually transmitted infections (STIs), unwanted pregnancy, maternal morbidity, negative sexual and reproductive health outcomes, and mental health conditions. The subsections below outline these consequences in detail.

### ***Injuries and Disabilities***

26. Evidence from the Region indicates that a substantial proportion of women living in situations of intimate partner violence experience physical injuries. In national surveys, the percentage of women in abusive relationships who reported being physically injured by a partner ranges from 41.2% (in Honduras, 2005-2006) to 81.6% (in Paraguay, 2008). In national surveys that assessed injury severity, the percentage of abused women who reported severe injuries (such as broken bones or deep wounds) ranged from 6.6% (in El Salvador, 2008) to 24.8% (in the Dominican Republic, 2007) (2).

### ***Mental Health and Substance Use***

27. Violence has profound mental health effects such as post-traumatic stress disorder (PTSD), depression, anxiety, and alcohol and drug use disorders (1). Globally, women

exposed to partner violence are twice as likely as other women to experience depression and almost twice as likely to have alcohol use disorders (1). Five national, population-based surveys from the Region found that large proportions of women who experienced partner violence in the past 12 months reported anxiety or depression so severe (as a result of their partner's aggression) that they could not complete their work or other obligations—ranging from nearly one-half of such women in Ecuador (2004) to more than two-thirds of women in Paraguay (2008) (2). In Guatemala (2008–2009) and Paraguay (2008), women who had experienced partner violence were significantly more likely than other women to contemplate or attempt suicide in the past month (2).

### *Sexual and Reproductive Health*

28. Research suggests that violence against women can have a host of negative sexual and reproductive health consequences. An analysis of national surveys from the Region found that intimate partner violence was significantly associated with unwanted or unintended pregnancy, greater parity, and first childbirth before age 17 (2). In some countries, unwanted pregnancy was two to three times more common among women who experienced partner violence compared with women who did not (2). The same study found that 3%–44% of women who had ever been pregnant had experienced partner violence during pregnancy (2). Violence during pregnancy has been associated with a higher risk of pregnancy complications, including miscarriage, preterm delivery and low birth weight (1, 23). Other consequences of intimate partner violence include gynecological disorders, and an increased risk of HIV (in some regions), syphilis, chlamydia, or gonorrhea (1).

### *Pregnancy-associated mortality*

29. Studies from high-income countries suggest that partner violence can be an important contributor to maternal mortality. In one province in Canada, hemorrhaging was three times more frequent among pregnant women exposed to violence (32). A review of 2003–2007 data from the U.S. Centers for Disease Control and Prevention (CDC) National Violent Death Reporting System found that 54% of suicides and 45% of homicides of pregnant or postpartum women were associated with intimate partner violence, and these deaths were important contributors to pregnancy-associated mortality (33). These findings have important implications for efforts to reduce deaths during pregnancy and postpartum.

### *Noncommunicable Diseases and Risk Factors*

30. Growing evidence suggests a link between experiencing intimate partner violence and an elevated risk of noncommunicable diseases such as overweight, diabetes, ischemic heart disease, stroke, and cancer (34, 35). Causal pathways are not yet clearly understood, but evidence suggests that the damaging effects of chronic stress, combined with survivors' greater likelihood of engaging in harmful behaviors such as smoking, overeating and low use of preventive health care such as cholesterol checks and

screenings for cervical or colon cancer may play a role (34, 35). Violence may also contribute to conditions such as chronic pain syndromes, irritable bowel syndrome, gastrointestinal disorders, somatic complaints and fibromyalgia (34, 35).

### ***Effects on Children***

31. Violence against women has important negative consequences for children. In addition to negative health outcomes mentioned above, evidence suggests that long-term health and social consequences of childhood exposure to intimate partner violence are similar to those of physical and emotional child abuse and neglect (23, 36, 37, 38). Childhood exposure to intimate partner violence has been linked to higher rates of under-five child mortality, (39) as well as to an increased risk of perpetrating or experiencing violence against women later in life (2, 40-42). Evidence from several countries in the Region suggests that children in households affected by violence against women are more likely than other children to be castigated with harsh forms of physical punishment (2). Pathways by which partner violence against women affects children is still under-researched, however, and merits greater attention.

### ***Economic Costs***

32. Violence against women imposes direct costs on health, social service, criminal justice and family court systems. A U.S. study found that health care expenditures were approximately 42% higher for women who had experienced partner violence compared with women who had not (43). Violence against women also imposes indirect costs on survivors, families, employers, and the broader society due to lost productivity and negative psychosocial consequences among women and their children. A comprehensive analysis from Canada estimated that the annual economic impact of spousal violence—including direct and indirect costs—was C\$ 7.4 billion (44). A World Bank analysis concluded that intimate partner violence costs Peru 3.7% of their gross domestic product (GDP), largely due to lost labor days (45). A study in Colombia found significantly greater unemployment levels and reduced earnings among survivors of violence (46).

### ***The Role of the Health System***

33. Health services can play an essential role in responding to violence against women. Health providers can identify women exposed to violence, provide immediate care, and mitigate harm through support and referrals to other sectors including legal and social services. Evidence suggests that women exposed to violence are more likely than non-abused women to seek health care but may not always disclose violence to their health providers (47). Initiatives to increase providers' early identification of women experiencing violence can improve their access to support, care, and referrals (48).

34. Health systems can also play a key role in multisectoral efforts to prevent violence. The public health approach to prevention involves four key steps: *a*) defining the problem by collecting data on the magnitude, characteristics and consequences of



violence against women; *b*) investigating risk and protective factors to understand why the problem occurs; *c*) developing, implementing, and evaluating violence-prevention strategies for health and other sectors; *d*) disseminating information on program effectiveness and scaling up effective programs (49). In the process, health systems should coordinate with other stakeholders and sectors (in particular, education and justice), as well as collaborate with national multisectoral coordination mechanisms and civil society organizations.

### **Strategy and Plan of Action**

35. This Strategy and Plan of Action reflects the cumulative efforts of national governments and women's movements to draw attention to and catalyze action to address violence against women. It also builds on a growing body of evidence, practice, norms, principles, standards, and technical guidelines developed over the last several decades by PAHO/WHO and others, as well as many other efforts across the UN system.

### ***Guiding Principles***

36. The following 10 principles, outlined in greater detail in Annex B, guide the Strategy and Plan of Action:

- a) universal access to health and universal health coverage and equity;
- b) human rights;
- c) gender sensitivity and equality and cultural/ethnic diversities;
- d) a multisectoral response;
- e) evidence-informed practice;
- f) life-course approach;
- g) a comprehensive response;
- h) community involvement;
- i) autonomy and empowerment of survivors;
- j) engaging men and boys.

### ***Overall Goal***

37. The overall goal of the Strategy and Plan of Action is to contribute to the reduction/eradication of violence against women. The strategic lines of action used in its implementation will promote the achievement of Outcome 2.3 of PAHO's Strategic Plan 2014–2019 and Outputs 2.3.2 and 2.3.3 of the PAHO Program and Budget 2014-2015.

***Strategic Lines of Action***<sup>3</sup>

38. The Strategy and Plan of Action will use the following strategic lines of action:
- a) strengthen the availability and use of evidence about violence against women;
  - b) strengthen political and financial commitment to addressing violence against women within health systems;
  - c) strengthen the capacity of health systems to provide effective care and support to women who have experienced intimate partner or non-partner sexual violence;
  - d) strengthen the role of the health system in preventing violence against women.

***Strategic Line of Action 1: Strengthen the availability and use of evidence about violence against women***

39. Understanding the nature, magnitude, risk and protective factors, and consequences of violence against women, including against indigenous and other racially and ethnically marginalized women, is the first step in preventing and addressing violence for several reasons. First, evidence-based, culturally relevant plans, policies, programs, and laws should be based on high quality quantitative and qualitative data, from both administrative data systems and population-based studies. Second, repeated data collection (ideally population-based) is needed to measure changes in levels of violence over time. Finally, in line with international human rights instruments applicable to health and the ethical principal of non-maleficence, data are essential for monitoring and evaluation to ensure that well-meaning interventions do not cause harm.

40. When generating evidence, efforts should be made to collect and analyze data on equity stratifiers (such as age, ethnicity/race, socioeconomic status, place of residence, sexual orientation and gender identity, among others) in order to advance knowledge about how social determinants influence violence against women. Partnering with academic and research institutions could expand the availability and use of evidence.

Objective	Indicator	Baseline (2015)	Target (2025)
<b>1.1</b> Increase the collection and availability of epidemiological and service-related data on violence against women	<b>1.1.1</b> Number of Member States that have carried out population-based, nationally representative studies on violence against women (or that have included a module on violence against women in other population-based demographic or health surveys) within the past five years	14	22

<sup>3</sup> Monitoring of indicators for each strategic line of action should take into account the shared responsibilities of federated States.

Objective	Indicator	Baseline (2015)	Target (2025)
	<b>1.1.2</b> Number of Member States that have carried out population-based, nationally representative studies on violence against women within the past five years (or that have included a module on violence against women in other population-based demographic or health surveys) that include an analysis of prevalence of violence against women across different ethnic/racial groups	2	10
	<b>1.1.3</b> Number of Member States that are able to provide data on homicide, disaggregated by age, sex, and relationship of the victim to the perpetrator	9	15

***Strategic Line of Action 2: Strengthen political and financial commitment to addressing violence against women within health systems***

41. The health system has an important role to play in challenging the acceptability of violence against women. A strong, visible health system response conveys a message to society regarding the unacceptability of violence, and encourages more women to disclose abuse to health professionals (47). However, given the multidimensional nature of violence against women, effective, comprehensive responses require the involvement of various sectors, including leadership, commitment and coordinated action among government leaders, policymakers, academics, legislators, national human rights commissions, law enforcement agencies, civil society and women's organizations and community members (50).

42. While many governments in the Region have developed national plans to address violence against women, there are often gaps between commitment and implementation. Effective implementation of national plans to prevent and respond to violence against women requires the availability of sound scientific evidence, the provision of robust support and know-how, and designated budgets within the health system (50).

Objective	Indicator	Baseline (2015)	Target (2025)
<b>2.1</b> Strengthen national and subnational policies and plans to address violence against women within the health system	<b>2.1.1</b> Number of Member States that have included violence against women in their national health plans and/or policies	18	35
	<b>2.1.2</b> Number of Member States whose national health budget has one or more dedicated lines to support prevention and/or response to violence against women	4	10

Objective	Indicator	Baseline (2015)	Target (2025)
	<b>2.1.3</b> Number of Member States that have established a unit (or units) or focal point(s) in the Ministry of Health responsible for violence against women	4	10
<b>2.2</b> Increase the health system's participation in multisectoral plans, policies and coalitions to address violence against women	<b>2.2.1</b> Number of Member States that have a national or multisectoral plan addressing violence against women that includes the health system, according to the status of the plan: <ul style="list-style-type: none"> <li>▪ in development;</li> <li>▪ currently being implemented</li> </ul>	13	20

***Strategic Line of Action 3: Strengthen the capacity of health systems to provide effective care and support to women who have experienced intimate partner and/or sexual violence***

43. Given the high prevalence of violence against women and evidence that abused women seek health care services more frequently than other women (even if violence is not the presenting health condition), it is imperative that health systems be prepared to offer survivors first-line support that responds to women's physical, emotional, safety, and support needs. Health professionals need training and tools to identify survivors, to deliver appropriate clinical care, and to refer them to other services, as needed. Given that many of the risk factors and determinants of violence lie outside the health system and in line with the "health in all policies" approach, health systems should pro-actively interact and coordinate with a number of other sectors, including: police and justice, social services, education, child protection, and gender equality or women's empowerment mechanisms.

44. Considering the disproportionate number of racially and ethnically marginalized women that experience violence in the Region, efforts should also include intercultural/culturally sensitive approaches to violence that reach beyond the formal health setting to include traditional health providers.

45. Acknowledging that children's exposure to intimate partner violence against their mother is associated with a range of negative outcomes, including greater risk of violence in adulthood, greater efforts should be made to identify mechanisms to safely and ethically coordinate services for women and for children exposed to violence.

Objective	Indicators	Baseline (2015)	Target (2025)
<b>3.1</b> Strengthen national standard operating procedures (protocols, guidelines) for providing safe and effective care and support for women experiencing intimate partner violence and/or sexual violence	<b>3.1.1</b> Number of Member States that have national standard operating procedures/protocols/guidelines for the health system response to intimate partner violence, consistent with WHO guidelines <sup>4</sup>	6	15
	<b>3.1.2</b> Number of Member States that provide comprehensive post-rape care services in emergency health services, consistent with WHO guidelines <sup>5</sup>	2	15
<b>3.2</b> Increase the capacity of health professionals to respond to violence against women	<b>3.2.1</b> Number of Member States that have included the issue of violence against women in their continuing education processes for health professionals	2	10

***Strategic Line of Action 4: Strengthen the role of the health system in preventing violence against women***

46. While addressing survivors' immediate needs is essential, long term reduction/elimination of violence depends on prevention. Similar to the ways in which it assumed responsibility for changing behaviors related to smoking and substance use, the public health community should raise awareness about violence against women as a public health problem.

47. The health system can contribute to preventing violence against women by gathering and disseminating evidence on the magnitude and consequences of violence; by developing and evaluating prevention programs and policies, and by scaling up promising or effective prevention strategies. These include programs that challenge attitudes and social norms that condone gender inequality and violence, that support socio-emotional learning and life skills that promote non-violent relationships, that reduce harmful use of alcohol, that aim to prevent child abuse (for example home visitation and parenting programs), and that assist children exposed to violence directly or as witnesses (50).

<sup>4</sup> At a minimum, protocols/guidelines for health system response should address: *a*) empathic and non-judgmental listening by health professionals; *b*) measures to help women enhance their safety; *c*) measures to help women enhance their children's safety and *d*) provision (directly or via referrals) of mental healthcare, social services, and legal support.

<sup>5</sup> Comprehensive post-rape care services include: *a*) first-line support and psychological first aid; *b*) emergency contraception to women who seek care within five days; *c*) referral to safe abortion if a woman is pregnant as a result of rape where such services are permitted by national law; *d*) STI and/or HIV post-exposure prophylaxis, per applicable protocols; and *e*) hepatitis B vaccination.

Objective	Indicators	Baseline (2015)	Target (2025)
4.1 Strengthen the participation and commitment of the health system in efforts to prevent violence against women	4.1.1 Number of Member States that have a multisectoral coalition/task force in place for coordinating efforts to prevent violence against women that includes the participation of Ministries of Health	3	10
	4.1.2 Number of Member States that have a national or multisectoral plan addressing violence against women (that includes the health system) that proposes at least one strategy to prevent violence against women, by type of strategy <sup>6</sup>	0	10

### Monitoring and Assessment

48. The Strategy and Plan of Action will contribute to Outcome 2.3 of PAHO's Strategic Plan 2014-2019 ("Reduced risk factors associated with violence and injuries with a focus on road safety, child injuries, and violence against children, women and youth") and Outputs 2.3.2 and 2.3.3<sup>7</sup> of the PAHO Program and Budget 2014-2015. Unlike other public health issues, addressing violence against women within health systems is a relatively new area of work for many Member States, so uniform baseline indicators are not available from all countries. To address this gap, PASB will develop a monitoring and evaluation plan and verify baseline data as part of implementing the Strategy and Plan of Action. Interim reports will be prepared for PAHO's Governing Bodies in 2018 and 2021 and a final report will be submitted in 2025.

### Financial Implications

49. The total estimated cost of implementing the Plan of Action over its lifecycle from 2015 to 2025, including expenses for staffing and activities, is US\$ 4,900,000.

### Action by the Directing Council

50. The Directing Council is invited to review the proposed Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women for

<sup>6</sup> Prevention strategies will be classified as follows: a) social and cultural norm change; b) *social-emotional learning approaches*; and c) *policy approaches (such as alcohol-related policies)*.

<sup>7</sup> Output (OPT) 2.3.2: Countries and partners enabled to assess and improve national policies and programs on integrated violence prevention, including violence against women, children, and youth. OPT 2.3.3: Countries enabled to develop and implement a national protocol for the provision of health services to victims of intimate partner and sexual violence in accordance with WHO 2013 guidelines.

2015–2025, consider approving the proposed resolution in Annex C, and provide recommendations it deems pertinent.

Annexes

## References

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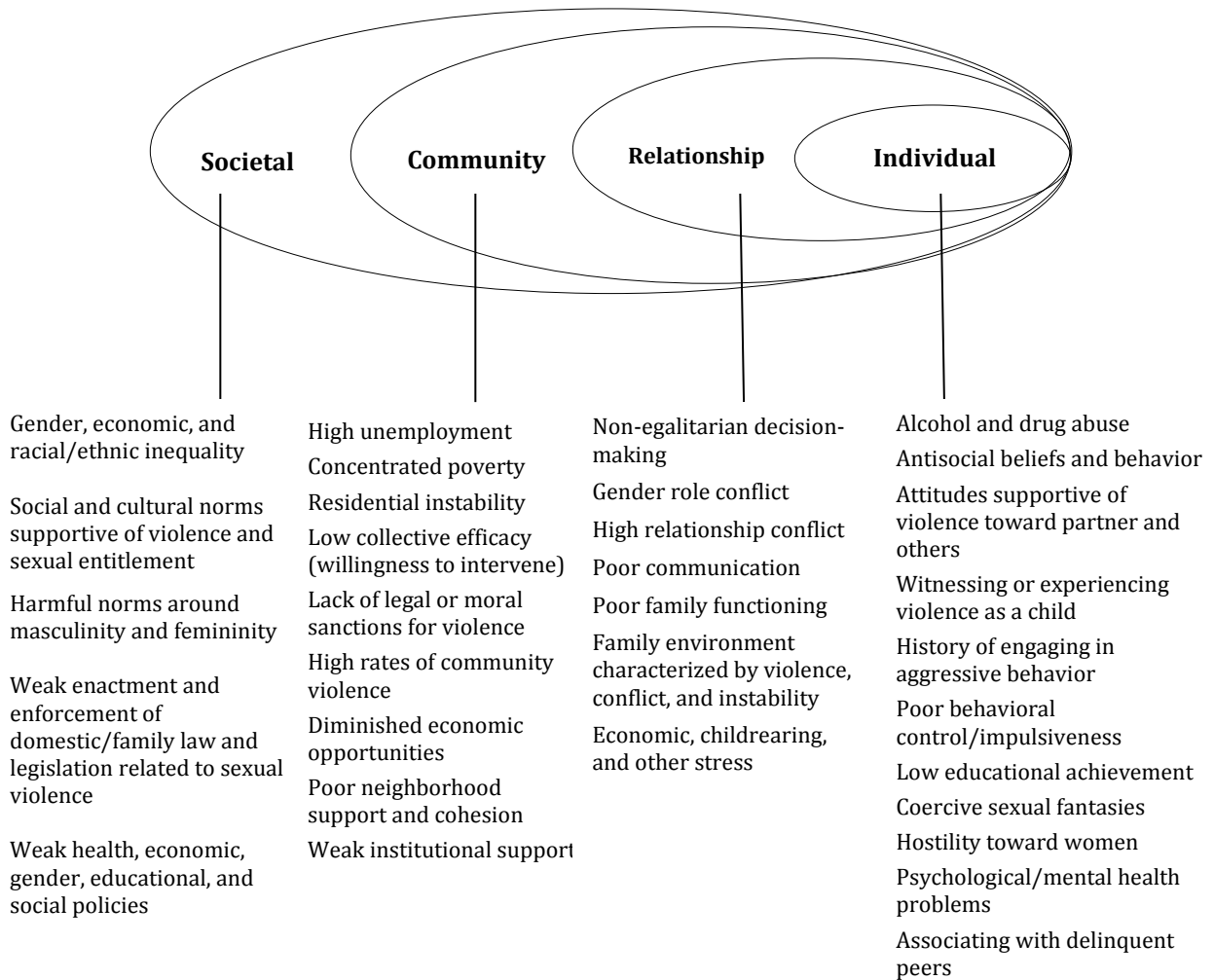
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**Annex A**

**Risk Factors associated with the Perpetration of Violence against Women**



Adapted from: WHO. *World report on violence and health*. 2002.; Heise, L. *What works to prevent partner violence: An evidence overview*. 2011.

## Annex B

### Guiding Principles

The following 10 principles guide this Strategy and Plan of Action:

- a) *Universal access to health and universal health coverage and equity*: Essential health services should be made available without risk of those needing services becoming impoverished or experiencing stigma or discrimination (on the basis of sex, age, socioeconomic status, ethnicity, or sexual orientation).
  
  - b) *Human and civil rights*: Human and civil rights are set forth in applicable international and regional treaties as well as in national constitutions and laws. Program, laws, policies, and services to prevent and respond to violence against women should be aligned with these and should, in particular, promote the following principles, as outlined in WHO's *Clinical Handbook: Health care for women subjected to intimate partner violence or sexual violence (51)*:
    - i. life: a life free from fear and violence;
    - ii. self-determination: being entitled to make their own decisions regarding medical care and legal action;
    - iii. the highest attainable standard of health: health services of good quality available, accessible, and acceptable to women;
    - iv. non-discrimination: health care services offered without discrimination, and treatment not refused based on sex, race, ethnicity, caste, sexual orientation, religion, disability, marital status, occupation, or political beliefs;
    - v. privacy and confidentiality: provision of care, treatment, and counseling that is private and confidential;
    - vi. information: the right to know what information has been collected and to have access to this information.
  
  - c) *Gender sensitivity and equality and cultural/ethnic diversities*: Prevention of and response to violence should also take into account gender norms, in particular, harmful constructions of masculinities that devalue the role of women, condone the use of violence, and blame women for the violence they experience. It is important to understand that violence against women is rooted in power imbalances and structural inequalities between women and men, that women may have less access than men to resources such as money or information, and that this may affect their ability to leave an abusive situation. It is also important to recognize and address multiple forms of discrimination that can contribute to increased vulnerability to violence on the basis of class, culture/ethnicity, age, disability, sexual orientation, gender identity, and others.
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- d) *A multisectoral response:* A health systems response to violence against women should be situated within a comprehensive and coordinated multisectoral response. This requires partnerships among multiple sectors, including health, machineries for advancement of women or promotion of gender equality, child protection, education, law enforcement, judicial and social affairs. It also requires coordination and partnerships between public and private sector, as well as civil society, professional associations, academia and other relevant stakeholders, as appropriate to each country's situation.
- e) *Evidence-based practice:* Programs, policies and services to prevent and respond to violence against women should be based on the best scientific evidence available and/or best practice consensus, and should be tailored to the specific sociocultural context.
- f) *Life-course approach:* This approach recognizes that positive and negative factors can influence the trajectories and outcomes of an individual's health and development, and acknowledges the different manifestations of violence throughout the life course.
- g) *A comprehensive response:* A comprehensive response to addressing violence also requires phased programming that takes into account varying stages of health systems development across countries.
- h) *Community involvement:* Efforts should be made to listen to the needs of community members—including those who are living with or have experienced violence—and meaningfully involving them in policy and program development and in monitoring and evaluation.
- i) *Autonomy and empowerment:* Programming should respect the autonomy of individuals to make full, free, and informed decisions regarding the care they receive and the services they choose to pursue. Programs, policies, and services also need to empower those who experience or are affected by violence by respecting their dignity; reinforcing their value as persons; not blaming or judging them for their experience of violence; and providing information, counseling, and services that enable them to make their own decisions.
- j) *Engaging men and boys:* Engaging men and boys in prevention is a critical component in efforts to promote gender equality, empower women, and change social and cultural attitudes, practices, and stereotypes that contribute to male violence against women.



Pan American  
Health  
Organization



World Health  
Organization  
REGIONAL OFFICE FOR THE  
Americas

## 54th DIRECTING COUNCIL

### 67th SESSION OF THE REGIONAL COMMITTEE OF WHO FOR THE AMERICAS

Washington, D.C., USA, 28 September-2 October 2015

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CD54/9, Rev. 2  
Annex C  
Original: English

### ***PROPOSED RESOLUTION***

#### **STRATEGY AND PLAN OF ACTION ON STRENGTHENING THE HEALTH SYSTEM TO ADDRESS VIOLENCE AGAINST WOMEN**

#### ***THE 54th DIRECTING COUNCIL,***

Having reviewed the *Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women* (Document CD54/9, Rev. 2);

Bearing in mind that the Constitution of the World Health Organization establishes that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition;”

Observing that violence against women constitutes a public health problem of grave proportions and a violation or an abuse of women’s human rights and fundamental freedoms, and impairs or nullifies the observance, enjoyment, and exercise of such rights and freedoms;

Deeply concerned that violence against women affects one in every three women in the Americas;

Aware that violence against women can take many forms, but that sexual, physical, and emotional violence perpetrated by a male partner against a woman is the most prevalent form of violence against women;

Cognizant that violence against women is rooted in gender inequality and in power imbalances between men and women;

Aware that such violence has long-lasting and profound consequences for women’s health, the health of their children, the well-being of their families and communities, and the economy and development of nations;

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Recognizing that health systems have an important role to play in preventing and responding to violence against women as part of a comprehensive and multisectoral effort;

Recalling Resolution WHA67.15 (2014), *Strengthening the role of the health system in addressing violence, in particular against women and girls, and against children*;

Recalling additional relevant PAHO Governing Bodies resolutions, including: Strategy for Universal Access to Health and Universal Health Coverage (CD53.R14 [2014]); Health and Human Rights (CD50.R8 [2010]); and Plan of Action for Implementing the Gender Equality Policy (CD49.R12 [2009]),

**RESOLVES:**

1. To approve and implement the *Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women* within the context of the particular conditions of each country.
2. To urge the Member States, taking into account the shared responsibilities in federated States, to:
  - a) improve the collection and dissemination of comparable data on the magnitude, types, risk and protective factors, and health consequences of violence against women;
  - b) strengthen the role of their health systems to address violence against women to ensure that all women at risk or affected by violence—including women in situations of vulnerability due to their socio-economic status, age, ethnic or racial identity, sexual orientation, gender identity and/or disabilities—have timely, effective and affordable access to health services;
  - c) encourage addressing violence against women in relevant health initiatives, including maternal and child health, sexual and reproductive health, HIV/AIDS, and mental health;
  - d) promote the engagement of the health system with other government and civil society partners as part of a multisectoral effort to address violence against women;
  - e) consider the related budgetary implications and safeguard adequate resources to support the implementation of efforts to address violence against women.

3. To request the Director to:
  - a) support the implementation of the Strategy and Plan of Action in order to maintain and strengthen collaboration between the Pan American Sanitary Bureau and the countries and territories to address violence against women;
  - b) continue to strengthen PAHO and WHO efforts to develop the scientific evidence on the magnitude, trends, health consequences and risk and protective factors for violence against women, and on effective strategies to prevent and respond to this type of violence;
  - c) continue to support countries and territories, upon their request, by providing technical assistance to strengthen the capacity of health systems to address violence against women;
  - d) facilitate PAHO cooperation with the human rights committees, bodies, and rapporteurships of the United Nations and Inter-American systems;
  - e) continue to prioritize the prevention of violence against women and consider the possibility of allocating additional resources for implementing the Strategy and Plan of Action.

## Report on the Financial and Administrative Implications of the Proposed Resolution for PASB

<p><b>1. Agenda item:</b> 4.6 – Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women</p>
<p><b>2. Linkage to Program and Budget 2014-2015:</b></p> <p>a) <b>Categories:</b> 2, Noncommunicable Diseases and Risk Factors, and 3, Determinants of Health and Promoting Health throughout the Life Course</p> <p>b) <b>Program Areas and Outcomes:</b></p> <p>Program Area 2.3 : Violence and Injuries Outcome (OCM) 2.3: Reduced risk factors associated with violence and injuries with a focus on road safety, child injuries, and violence against children, women, and youth.</p> <p>Program Area 3.1: Women, Maternal, Newborn, Child, Adolescent, and Adult Health, and Sexual and Reproductive Health OCM 3.1: Increased access to interventions to improve the health of women, newborns, children, adolescents, and adults.</p>
<p><b>3. Financial implications:</b></p> <p>a) <b>Total estimated cost for implementation over the lifecycle of the resolution (including staff and activities):</b> US\$ 4,900,000</p> <p>b) <b>Estimated cost for the 2016-2017 biennium (including staff and activities):</b> \$980,000</p> <p>c) <b>Of the estimated cost noted in b), what can be subsumed under existing programed activities?</b> The Bureau has one staff member in the area of violence against women, and limited funding for programmatic work in this topic area is included in the PAHO Strategic Plan 2014-2019; however, additional financial and human resources would be necessary for scaling up prevention and response to violence against women in the Region, particularly for the provision of technical support to Member States and territories.</p>
<p><b>4. Administrative implications:</b></p> <p>a) <b>Indicate the levels of the Organization at which the work will be undertaken:</b> This work will be carried out at all levels of the Organization: country, subregional and regional. Additionally, cross-regional collaborations will also be pursued.</p> <p>b) <b>Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile):</b> In order to scale up efforts in the area of violence against women, another professional would be needed.</p> <p>c) <b>Time frames (indicate broad time frames for the implementation and evaluation):</b> The proposed resolution covers the period 2015-2025 and requires effort and commitment on the part of all the Member States and the Pan American Sanitary Bureau.</p>

## ANALYTICAL FORM TO LINK AGENDA ITEM WITH ORGANIZATIONAL MANDATES

1. **Agenda item:** 4.6 - Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women
2. **Responsible unit:** Family, Gender and Life Course (FGL/HL)
3. **Preparing officer:** Alessandra Guedes
4. **Link between Agenda item and Health Agenda for the Americas 2008-2017:**

While preventing and responding to violence against women is linked to most of the areas of action outlined in the Health Agenda for the Americas, the action areas below are the most pertinent:

  - Tackling Health Determinants
  - Increasing Social Protection and Access to Quality Health Services
5. **Link between Agenda item and the amended PAHO Strategic Plan 2014-2019:**

Preventing and responding to violence against women is directly related to most of the categories of the PAHO Strategic Plan 2014-2019; however, the categories below are the most pertinent:

Category 2: Noncommunicable Diseases and Risk Factors

Category 3: Determinants of Health and Promoting Health throughout the Life Course

Category 4: Health Systems
6. **List of collaborating centers and national institutions linked to this Agenda item:**

There are five collaborating centers working on violence and injuries prevention in the Americas, including:

  - Canada: Collaborating Centre for Safety Promotion and Injury Prevention/National Public Health Institute of Quebec
  - Brazil: Center for the Study of Violence (Núcleo de Estudos da Violência)/University of São Paulo
  - Mexico: Instituto Nacional de Salud Pública
  - USA: International Injury Research Unit / Johns Hopkins University
  - USA: National Center for Injury Prevention and Control / Centers for Disease Control and Prevention

PAHO also has ongoing collaborative efforts with a number of additional organizations, including UN agencies (UNICEF, UN Women, UNFPA), academic centers (George Washington University, Johns Hopkins University School of Nursing) and others (Inter-American Development Bank, World Bank, Organization of American States).

**7. Best practices in this area and examples from countries within the Region of the Americas:**

- Develop the scientific evidence on the magnitude, trends, health consequences and risk and protective factors for violence against women.
- Strengthen the capacity of health systems so that health professionals are able to identify and provide timely, safe and effective care and support for women experiencing intimate partner violence or sexual violence.
- Invest in evidence-based prevention strategies that target key risk factors, including but not limited to:
  - challenging gender norms that condone the use of violence against women;
  - preventing child maltreatment;
  - preventing the harmful use of alcohol.
- Ensure that violence against women is addressed within relevant health programs, including maternal and child health, sexual and reproductive health and mental health.

**8. Financial implications of this Agenda item:**

- The total estimated cost for implementation over the lifecycle of the resolution (2015-2025) is US\$ 4,900,000.
- The estimated cost for the 2016-2017 biennium is approximately \$980,000.

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